Vermont EMS Today

December 2000

From the Director

Changes in Emergency Cardiac Care: What Does it all Mean?

Have you had a look at the new Heart Association guidelines for Basic and Advanced Cardiac Life Support? If you haven't, get a copy of the fall 2000 edition of *"Currents"* the American Heart Association's publication that describes the most recent guidelines. It describes many of the changes you will experience in how resuscitations are performed by rescuers at public, EMS and hospital levels. Given the percentage of patients in every EMS system that present with symptoms of a cardiac emergency, the Heart Association's work warrants our collective attention. I want to share some thoughts on what the new material means and where it came from.

Let's begin with the understanding that the Heart Association's guidelines are just that, guidelines. They are not standards of care.

Let's begin with the understanding that the Heart Association's guidelines are just that, guidelines. They are not standards of care. The regimens of treatment described do not represent firm clinical protocols. At its recent annual meeting, the National Association of State EMS Directors passed a resolution calling for state EMS offices to work with the National Association of EMS Physicians and the American College of Emergency Physicians to develop strategies for implementing the new guidelines within EMS systems. This resolution recognized the variations possible within the new guidelines and the challenges that this will present to EMS systems.

Similarly, persons who complete American Heart Association training programs such as Basic Life Support for the Professional Rescuer or Advanced Cardiac Life Support are not certified by the Heart Association. The American Heart Association is trying to distance itself from the image of a certifying agency that has any authority to require or verify competency to perform particular resuscitation skills. If that sounds like a move intended to reduce the Heart Association's liability exposure, you are right.

Some observers embrace the direction of the American Heart Association. They accurately suggest that medicine cannot be practiced in any setting without engaging the brain. By recognizing latitude in treatment options, a wider range of valid physician preferences can be accommodated when there

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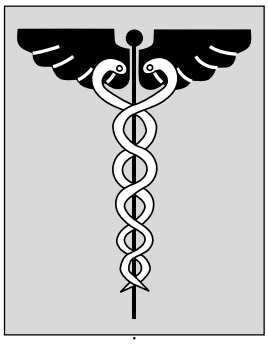

If you have been in EMS since the 1970s (or even before), as I have been, you too have come to expect that there will be changes in CPR. Not to disappoint us, the American Heart Association has once again planned changes to how we teach and provide cardio-pulmonary resuscitation. In *Currents*, Volume 11, Number 3, Fall 2000, we find the basis for our latest anticipated changes.

The new guidelines are at least "interesting" and may potentially significantly impact EMS systems in the United States, according to information supplied by the state EMS medical directors during their annual meeting recently in San Diego, California. The changes in CPR that the Heart Association has put forward claim to be, "…internationally developed, science-based, and evidence-based…All new guidelines were rigorously reviewed, adhering to the principles of evidence-based medicine." Among the changes are:

AHA advocates for "searching for and honoring, 'Do Not Attempt Resuscitation' (DNAR) status in field, emergency department, and hospital." Citing, "…living wills, advance directives, or other documents and even bracelets and anklets worn on the body," they state, "valid expressions of self-determination must be honored; to do otherwise is unethical and prohibited by law." Exactly what this will mean for Vermont, I am uncertain.

"Certification of Death in the Field-No Transport:" AHA states, "there are very few indications for transporting a victim of nontraumatic cardiac arrest who has failed a successfully executed prehospital ACLS resuscitation effort to an Emergency Department to continue the resuscitation attempt." We note that the arrested party needs to have had a failed ACLS resuscitation effort in the field. *Currents* goes on to cite some of the criteria for ceasing the resuscitation in the field.

The importance of early defibrillation is emphasized by AHA. Their strong advocacy for defibrillation will allow for the placement of defibrillators throughout our communities for use by the general public and others. Whether or not countless lives will in fact be saved, whether or not their use will delay or confuse EMS responses and whether or not there will be a smooth interface with EMS (think of the victim who has had a few shocks delivered but then a different machine is attached for transport, or the hospital receiving the patient requests to see the patient's rhythms from the AED) remain to be seen.

The new guidelines appear to teach a difference between "phone fast" and "phone first." Generally, it appears that rescuers will be instructed to "phone first," that is, phoning the EMS system before starting CPR, except for a few situations like:

- Submersion/near drowning
- Poisoning, drug overdose
- Trauma, and
- Respiratory Arrest.

A skill near and dear to each of us has gained some prominence in the new guidelines: bag-mask ventilation is emphasized. According to *Currents*, "Anyone providing prehospital BLS care for adults, infants, and children should be trained to deliver effective oxygenation and ventilation using a bag-mask technique as the primary method of ventilatory support, particularly if the transport time is short."

The importance of early defibrillation is emphasized by AHA.

The new guidelines will stress smaller tidal volumes during adult rescue breathing to lessen the risk of gastric inflation. In addition, mouth-to-nose breathing as an alternative to mouth-to-mouth or mouth-to-nose-and-mouth breathing for infants will be presented.

The area of alternative airway devices is also covered in the new guidelines. Whereas endotracheal intubation was formerly stressed as the "gold standard" for airway control, other methods receive some further consideration.

Interestingly, the "pulse-check" will not be taught to lay rescuers. Instead, lay rescuers will be taught to look and examine for "signs of circulation." If no signs of circulation are detected, the rescuer should begin chest compressions and attach an AED.

For lay rescuers (not us), relief of foreign-body airway obstruction in the unresponsive victim will be simplified. The lay rescuer will provide standard CPR to these victims.

Everyone will be adjusting the rate of chest compressions and ratios of

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Vermont EMS Today
is published as a service for Vermont's emergency medical providers. Suggestions, comments and news items are always welcome. Write or call Leo J. Grenon, Vermont Dept. of Health, 108 Cherry Street, Box 70, Burlington, VT 05402. (802) 863-7310 or 1-800-244-0911 (in Vermont only). Email: VTEMS@VDH.STATE.VT.US

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From the Director—

Changes in Emergency Cardiac Care…

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is not a clearly superior choice of treatment. Others say that the origins of Basic CPR and ACLS were to give varying levels of clinicians a common standard approach to managing cardiac emergencies. They question how we will be able to consistently treat cardiac patients without a single defined pathway of care.

The changes to the Heart Associations guidelines reflect the best available national and international research combined with the expert judgement of various committees who developed the material contained in the guidance. The Heart Association should be commended for its effort to reflect state of the art knowledge and expertise in steering worldwide thinking about treatment of cardiac emergencies. At the same time, we must acknowledge the limitations of that effort.

One limitation is the need for more and better research. At least one of the drugs included in the recommended approach to managing certain cardiac arrhythmias has not been shown to result in increased survival. While the drug has been demonstrated as effective in halting certain arrhythmias, it has yet to be shown to make any difference in lives saved.

Doing good research is hard. It can be expensive and sometimes has ethical implications as well. A prominent EMS physician recently pointed out that we probably don't have any good research demonstrating the effectiveness of direct pressure on hemorrhage control. Would anyone really want to do a randomized clinical study to compare the outcomes of severely bleeding patients who received direct pressure versus those who don't?

Another concern is about the involvement of various drug and equipment manufacturers in the Heart Association's guideline development process. Do you think there is any likelihood that a representative from a defibrillator manufacturer would vote against a guideline calling for widespread public training in use of automated defibrillators?

On page two of this newsletter, Dr. Wayne Misselbeck, VT EMS Medical Advisor, describes a number of specific guideline changes that will likely affect EMS providers. As Vermont's EMS system matures, change becomes an expected part of the EMS culture. We will do everything possible to be certain that the changes are incorporated in a way that benefits patients and advances our system of emergency care.

— Dan Manz, State EMS Director

Best Wishes for the Year 2001

Another successful year has passed for the *Vermont EMS Today* newsletter. Thank you again for the support you have given us in yet another year of its publication. Please do not hesitate to send in announcements, articles, etc. We will make every effort to publish them. The Vermont Department of Health EMS Staff wishes you and yours a safe and happy 2001!

Dan Manz, EMS Director
Send Comments and articles to:
Vermont Department of Health
Emergency Medical Services
Attn: Leo J. Grenon, *VT EMS Today*
108 Cherry Street, P.O. Box 70
Burlington, Vermont 05402

DON'T FORGET!

2001 EMS **Conference**

March 31 & April 1

Preconference
March 29–30

MARCH 31 & APRIL 1

Emergency Medical Services for Children

I would like to take this opportunity to introduce myself as the new Pediatric EMS Coordinator for the Vermont EMS Office. I have been involved in EMS for around 8 years as a volunteer EMT-I with Vergennes Rescue, and as a Vermont EMS Instructor/Coordinator.

One of my primary responsibilities will be to act as a contact and resource person for pediatric EMS issues. Please feel free to contact me with any of your pediatric EMS needs or inquiries. I can be reached at (800) 244-0911 or by email at: *wclark@vdh.state.vt.us*

I will also be responsible for developing and coordinating an EMS data collection system. As many of you know, Vermont does not have a statewide system to collect EMS call data. Some EMS agencies in Vermont already use databases to store their EMS call data, however, there is still a need to collect this data on a state-wide basis.

This data collection project is still in its very early stages. There are dozens of questions to answer and challenges to work through, but one thing is already apparent: a well designed database of Vermont EMS calls will go a great way toward improving the health of Vermonters. We will be able to take a good look at the work we do as EMS providers and find ways to improve the care we deliver to our patients. Anyone who would like more information about this project is encouraged to contact me.

On a different note, most EMS providers are familiar with the many challenges presented when transporting pediatric patients. The one question that often arises is, "Can we safely transport a child on a stretcher designed for adults? If not, how can we be sure that car seats adapted for ambulance use are safe and reliable?"

The truth is, we can't conclusively answer these questions yet. What is clear is that more research needs to be done on ambulance crashes involving pediatric patients. The following is a statement released by the National Highway Traffic Safety Administration and the Maternal & Child Health Bureau:

The Do's and Don'ts of Transporting Children in an Ambulance

Approximately six million children are transported by emergency medical services (EMS) vehicles each year in the United States. There are risks of injury associated with transport that can be minimized. An ambulance is NOT a standard passenger vehicle. Unlike the well-developed and publicized child passenger safety standards and guidelines, specifications for the safe transport of ill and injured children in ambulances are still under development. Standard automotive safety practices and techniques cannot be applied directly to EMS vehicle environments due to biomechanical and practical differences. Caution is encouraged in the application of passenger vehicle principles to ambulances and in the utilization of new and unproven products.

The Emergency Medical Services for Children (EMSC) Program supports efforts to improve the safety of pediatric patients being transported in EMS vehicles. Through an EMSC grant, the Division of Pediatric Emergency Medicine at Johns Hopkins Children's Center is working to fill critical knowledge gaps and developing standards for pediatric EMS transport safety. Project results should be available soon.

A national consensus committee, sponsored by the EMSC Program, is reviewing current EMS child transportation safety practices. The group, which includes representatives from EMS national organizations, federal agencies, and transportation safety engineers, is developing preliminary recommendations for EMS providers until scientific research is completed.

There are certain practices that can significantly decrease the likelihood of a crash, and in the event of a crash or near collision, can

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From The Medical Advisor

A Challenge: How we do Business

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compressions to ventilations. Everyone will provide compressions at a rate of about 100 compressions per minute and at a ratio of 15 compressions to 2 breaths in an effort to improve blood flow. "Professional" responders will still use a 5:1 ratio in pediatric arrests, according to *Currents.*

If the public is reluctant to perform ventilations on an arrested victim, they will be instructed to open the airway and perform chest compressions.

And concerning infants, "the 2 thumb-encircling hands technique of chest compression is preferred for chest compressions in infants performed by healthcare providers when 2 rescuers are available."

In addition, according to the guidelines, "an AED can be used in children 8 years of age and older."

For our current Vermont paramedics, look forward to some potential changes around the use of Bretylium (it is out), lidocaine (it appears to be secondary to amiodarone) and epinephrine (you might be changing to vasopressin).

According to the state EMS medical directors, some systems adopting the new standards will face significant costs and logistical issues. Some of the systems may actually revert from an ALS system to a lower level of care. Some systems may not adopt the changes, they say, and face some legal issues.

No doubt the new guidelines will challenge us to change how we do business. There is little "new" in that. At least since I began in EMS in the 1970s, change has been a part of us. No doubt we all look forward to the purported benefit to our patients that these changes offer.

— Wayne Misselbeck, M.D.,
State Medical Advisor

EMSC: The Do's and Don'ts of Transporting Children in an Ambulance

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significantly decrease the potential for injury. These practices are listed below. Importantly, as is mandated in several states, the NHTSA Emergency Vehicle Operating Course (EVOC), National Standard Curriculum or its equivalent is an integral part of this transport safety enhancement.

Pending research and consensus outcomes, the following guidelines for good practice should be observed when transporting children in EMS vehicles.

Do's

- ✓ DO drive cautiously at safe speeds observing traffic laws.
- ✓ DO tightly secure all monitoring devices and other equipment
- ✓ DO ensure available restraint systems are used by EMTs and other occupants, including the patient.
- ✓ DO transport children who are not patients, properly restrained, in an alternate passenger vehicle, whenever possible.
- ✓ DO encourage utilization of the DOT NHTSA Emergency Vehicle Operating Course (EVOC), National Standard Curriculum.

Don'ts

- ✘ DO NOT drive at unsafe high speeds with rapid acceleration, decelerations, and turns.
- ✘ DO NOT leave monitoring devices and other equipment unsecured in moving EMS vehicles.
- ✘ DO NOT allow parents, caregivers, EMTs or other passengers to be unrestrained during transport.
- ✘ DO NOT have the child/infant held in the parent, caregiver, or EMT's arms or lap during transport.
- ✘ DO NOT allow emergency vehicles to be operated by persons who have not completed the DOT EVOC or equivalent.

— William Clark,
Vermont Pediatric EMS Coordinator

U.S. Department of Transportation
National Highway Traffic Safety Administration

U.S. Department of Health & Human Services
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau

13th Annual Vermont EMS Conference
Awards Criteria

As EMS Conference 2001 approaches it is time again to consider nominating individuals or services for the 13th annual EMS Awards. Since our first conference in 1989, 90 of Vermont's EMS providers have been recognized for their outstanding contributions to EMS. Enclosed in this newsletter is a helpful form to assist those wishing to submit nominations. Feel free to make copies as necessary. Additional forms and criteria are available at our WEB site at: *http://www.state.vt.us/health/ems.*

When writing a nomination letter remember that one quality nomination letter is of greater significance then several poorly crafted ones. Leave yourself enough time to write a nomination that is easily read and thorough in describing the accomplishments of your nominee. It is a rare occasion that we take the time to recognize accomplishments in EMS; take the time to let us know. Below are a few helpful hints to consider when submitting a nomination:

- ★ Consider the correct award criteria for the individual you are interested in nominating.
- ★ Remember, awards are based on an individual or service's overall contribution to the field of EMS. Avoid focusing on single acts of heroism.
- ★ Make sure to completely identify the individual or service at some point in the nomination and the exact award you wish them to be nominated for. Frequently we receive letters that do not specify the award category.
- ★ Make a simple outline of your thoughts. Jumbled information is confusing and often clouds the characterizations that recognize outstanding members.
- ★ When you write your nomination, keep in mind that it will be read by several committee members who may have no familiarity with the person or service.
- ★ And finally, have someone proofread your work.

EMS Awards Information

The annual Vermont EMS awards ceremony is a public opportunity to recognize our state's finest EMS professionals. In many ways, these are the "people's choice" awards. Nominations come from colleagues, friends, other public safety agencies, municipal officials and grateful patients. The selection of the 2001 award recipients is done by committees of peers, including the 2000 award winners. Nominations for this year's 2001 awards program must be received by **Friday, March 9th, 2001.**

FIRST RESPONDER (EMERGENCY CARE ATTENDANT) OF THE YEAR

- ★ Is a currently certified Vermont ECA.
- ★ Has made exceptional contribution to his/her EMS organization.
- ★ Has strong and consistent clinical skills at his/her certification level.
- ★ Has made an outstanding contribution to the EMS system either within or outside his/her squad or service.

EMT-BASIC OF THE YEAR

- ★ Is a currently certified Vermont EMT-Basic.
- ★ Has made exceptional contribution to his/her EMS organization.
- ★ Has strong and consistent clinical skills at his/her certification level.
- ★ Has made an outstanding contribution to the EMS system either within or outside his/her squad or service.

EMT-INTERMEDIATE OF THE YEAR

- ★ Is a currently certified Vermont EMT-Intermediate.
- ★ Has made exceptional contribution to his/her EMS organization.
- ★ Has strong and consistent clinical skills at his/her certification level.
- ★ Has made an outstanding contribution to the EMS system either within or outside his/her squad or service.

EMT-PARAMEDIC OF THE YEAR

- ★ Is a currently certified Vermont EMT-Paramedic.
- ★ Has made exceptional contribution to his/her EMS organization.
- ★ Has strong and consistent clinical skills at his/her certification level.
- ★ Has made an outstanding contribution to the EMS system either within or outside his/her squad or service.

EMS EDUCATOR OF THE YEAR

- ★ Has made a recognized contribution to the Vermont EMS system through outstanding organization or delivery of education to EMS providers.

EMS LEADER OF THE YEAR

- ★ Is a leader of either a Vermont licensed ambulance service, first responder service, EMS district, hospital, or the community.
- ★ Has played a major role in either EMS system development or the development of an individual EMS organization.
- ★ Has demonstrated leadership.
- ★ Has represented the EMS system in a positive manner to other groups and organizations.

EMS NURSE OF THE YEAR

- ★ Is currently a licensed nurse at any level.
- ★ Has made an exceptional contribution to the Vermont EMS system.

EMS PHYSICIAN OF THE YEAR

- ★ Is a currently licensed physician.
- ★ Has made an exceptional contribution to the Vermont EMS system.

FIRST RESPONDER SERVICE OF THE YEAR

- ★ Is a currently licensed first response service based in Vermont (licensure level is not to be considered)
- ★ The service has made an outstanding contribution in the past year to public education.
- ★ The service maintains positive, outstanding relations with the communities it serves and the local EMS District Board.

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★ The service takes meaningful and visible steps to assure the professionalism of personnel and the quality of patient care.
★ The service has identified areas in which performance could be improved, and has taken organized steps to improve those areas in the past 2-3 years. (Examples could be: response times, quality improvement programs, advanced levels of training)

AMBULANCE SERVICE OF THE YEAR

★ Is currently a Vermont licensed ambulance service (licensure level is not to be considered)
★ The service has made an outstanding contribution in the past year to public education.
★ The service maintains positive, outstanding relations with the communities it serves and the local EMS District Board.
★ The service takes meaningful and visible steps to assure the professionalism of personnel and the quality of patient care.
★ The service has identified areas in which performance could be improved, and has taken organized steps to improve those areas in the past 2-3 years. (Examples could be: response times, quality improvement programs, advanced levels of training)

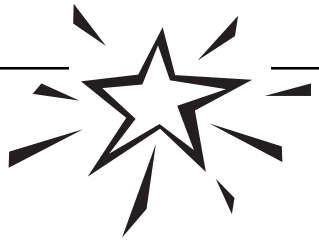
VERMONT SAFE KIDS INJURY PREVENTION AWARD

★ Is currently affiliated with an emergency medical services district or a licensed ambulance or first responder service in Vermont.
★ Has made an exceptional contribution to his/her organization in the area of injury prevention or public education.
★ Has made an exceptional contribution to the promotion of injury prevention and public education in emergency, medical services.

VERMONT AMBULANCE ASSOCIATION EDUCATION SCHOLARSHIP AWARD

Vermont Ambulance Association is pleased to offer a scholarship in the amount of $500, available to any member in good standing of a licensed VT EMS organization. This is to further their education in the provision or management of medical care. Recipients will be chosen by the VAA. Submit nominations or applications to the VT EMS office.

— Rob Schell, Operations Coordinator



Thanks!

The EMS State Staff thanks all of our pre-hospital providers for the dedicated services you have given to the people of Vermont in the year 2000.

★

Dan Manz
William Clark
Leo J. Grenon
Donna Jacob
Wayne Misselbeck
Mike O'Keefe
Rob Schell
Ray Walker

★

2000 EMS Award Winners!

Again we acknowledge and congratulate the 2000 EMS Award Winners:

First Responder of the Year
Matthew Boulac
South Royalton Rescue

EMT-Basic of the Year
Joan Huestis
Town Line First Response, Bridport

EMT-Intermediate of the Year
Linda Carroll
Chester Ambulance Service

EMT-Paramedic of the Year
Carl Matteson
LeFevre Ambulance Service, Bellows Falls

EMS Educator of the Year
Scott Gagnon
Barre City Ambulance

EMS Leader of the Year
Mark Considine
Rescue Inc., Brattleboro

EMS Nurse of the Year
Kelly Quilliam, R.N.
Northwestern Medical Center

EMS Physician of the Year
Stanley Baker, M.D.
Northeastern Vermont Regional Hospital

First Responder Service of the Year
Georgia First Response, Georgia

Ambulance Service of the Year
Calex Ambulance Service, St. Johnsbury

Vermont SAFE Kids Injury Prevention Award
Michael Rock
AmCare Ambulance Service, St. Albans

Training UPDATE

Counting of Ballots and Other Items

In light of recent difficulties with counting ballots in the presidential election, the EMS Office wants all providers to know that we have had a longstanding policy of hand checking any failures on the written EMT-B recertification or EMT-Intermediate examination. Several things have become apparent in this process: candidates sometimes do not erase previous answers completely or they sometimes leave a few questions unanswered and a hand check sometimes changes a failing grade to a passing grade. Failures on practical examination stations receive similar scrutiny. Only after these steps have taken place does a candidate receive notification of failure of a portion of the certification exam.

Taking Exams at the EMS Office

Candidates are welcome to take or re-take a written exam at the EMS office during regular business hours. Here are a few reminders about the process.

- A candidate should call EMS at 863-7310 or 1-800-244-0911 beforehand to set up an appointment. The number of spaces where candidates can take exams is limited, so space is filled on a first come, first serve basis.
- You can take a written exam at the office, but not a practical exam. The facilities, equipment and personnel necessary for a practical exam are not available.
- You may start an exam between 8:30 a.m. and 2:00 p.m. Monday through Friday, excluding state holidays. This insures your exam will not go beyond the end of the business day (4:30 p.m.). Even if you always finish exams before time is up, we must make sure you have all the time available that you are entitled to.
- The time limits for the exams are:

  National Registry First Responder—1 hour 40 minutes

  National Registry EMT-Basic—2 hours 30 minutes

  Vermont EMT-B recertification—2 hours

  Vermont EMT-Intermediate—2 hours
- Be sure to bring photo ID so we can verify your identity. The National Registry has required this for years to prevent someone from taking an exam for a candidate. When an entire class takes an exam, the instructor-coordinator (IC) can vouch for the identities of students in the class.
- You can park for free in the underground parking garage at 108 Cherry Street — unless you have a tall vehicle that is too tall for the low overhead (approximately six and a half feet).
- If you need to change or cancel an appointment, please call. If you miss your appointment without notifying us, someone else may be inconvenienced.
- Directions to the Department of Health building are on the web site and are also available from the staff member who makes your appointment.
- Any staff member in the office should be able to make your appointment. You do not need to speak to a specific person.

EMS Instructor Course

The next EMS Instructor Course will take place January 27 and 28, February 10 and 11, and March 3 and 4, 2001, at the University of Vermont in Burlington. District chairs and trainers should have received applications.

The course is open to EMTs who are recommended by a district board. Space is limited and each applicant must have the support of a district board. Preference will be given to applicants who have demonstrated an interest in and commitment to teaching.

The purpose of the EMS instructor course is to prepare EMTs to coordinate courses at the EMT-B level and above. It is not a means of preparing training officers. The investment of time and energy a candidate must devote to the course is significant, so it is generally not the most prudent use of resources for a district to recommend someone for the course who plans to teach only at the first responder level.

EMT-Intermediate Curriculum

EMS has begun the process of evaluating the new national standard EMT-Intermediate curriculum for use in Vermont. In August, each district medical advisor received a survey asking whether each of the interventions in the new national curriculum should be in the next Vermont curriculum. The responses varied significantly, ranging from maintaining the status quo to outright adoption of the whole curriculum, with most respondents giving answers somewhere in between.

The next step in the process is for EMS Office staff to meet with the district medical advisors to gain a consensus of what the EMT-I of the future should look like. District and other officials will then have an opportunity to participate in the process by considering how much of the medically acceptable material is feasible and reasonable in Vermont. This will take place only after the district medical advisors say what they wish to have for the maximum medical content of the curriculum.

The new curriculum, as written, includes many more interventions and requires significantly more time to complete (300-400 hours compared to the present 83 hours). There is also a need for much more clinical time and supervised field experience.

In their responses to the survey, the district medical advisors generally agreed that certain interventions should be in the new course, including peripheral intravenous therapy, phlebotomy, 50% dextrose, 1:1000 epinephrine, naloxone (all of which are currently included), the Esophageal Tracheal Combitube instead of the esophageal obturator airway, pulse oximetry, blood glucose measurement, aspirin and beta agonist bronchodilators. They also generally agreed that certain interventions should not be in the new course, including intraosseous infusion, pediatric endotracheal intubation, automated transport ventilators and nasogastric and orogastric tubes. There was a wide range of opinion on whether to include many other interventions such as endotracheal intubation of adults, needle chest decompression, glucagon, thiamine, ECG rhythm interpretation and intravenous cardiac medications. In a number of cases, every response, from "strongly disagree" to "strongly agree," received one or more votes.

The primary goal of the meeting with district medical advisors is to reach a consensus on these issues. Medical advisors, after discussing these issues with each other and considering the evidence, may change their minds about certain interventions. Many questions will arise in this process, some of which will require considerable thought and discussion. After this important step has taken place, district and other officials will meet to take the next step in this process. EMS will keep providers informed of developments in this process.

Year in Review

The state's fiscal year ended June 30, providing us with an opportunity to look at what happened in training and education during fiscal year 2000.

Continuing Education

Once again, more than 700 people attended the Vermont EMS conference in the spring. The twelfth annual conference saw the return of several popular speakers from past conferences, as well as some new faces. The popularity of pre-conference workshops continued to grow, with some sessions unable to accept all of the people who wished to attend. EMS Office staff also provided initial and continuing education by opening a number of EMT-Basic and EMT-Intermediate courses and making other presentations to EMS providers.

Implementation of 1994 EMT-Basic Curriculum

The last three EMT-B transition courses have taken place, bringing an official end to the transition of existing EMTs to the 1994 EMT-B curriculum.

Courses

The last 19 first responder courses under the old curriculum took place this year. Turnaround time for approvals by the EMS office (once the application was complete) was timely. Eighty-four percent of courses were approved within two weeks, the time instructors have to submit the course application before it starts. More than half of the courses were approved on the same day the applications were complete.

The number of EMT-Basic courses increased slightly over last year, (see below) although there was a slight decrease in the number of EMT-Intermediate courses. EMT-B refresher courses increased significantly, going from two to eleven in the second year they have been taking place in Vermont.

Approvals for EMT courses were also tracked. Eighty percent of course

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	1993	1994	1995	1996	1997	1998	1999	2000
Basic	14	16	17	10	16	17	21	25
Intermediate	11	12	11	14	7	10	11	8
Basic Refresher	NA	NA	NA	NA	NA	NA	2	11
TOTALS (without refresher courses)	25	28	28	24	23	27	32	33

What's Spreading in Infectious Disease

Infection Control Officer's Manual

The EMS Office is sending to each licensed service's designated officer (DO) for infection control a copy of a new document, an Infection Control Officer's Manual. The manual provides basic information on requirements a service must meet, in addition to a number of documents that provide helpful information on infectious diseases.

EMS is doing this to assist services in meeting the requirements of other agencies (EMS does not have any rules about infectious disease, but agencies such as the Occupational Safety and Health Administration do). The EMS Office frequently receives a call from a DO inquiring how to meet certain requirements he was told the service must meet. Sometimes there is no such requirement. Sometimes there is a requirement, but it was not what the DO heard. By providing source documents that specify the requirements a service must meet, this manual should help to inform providers and prevent misunderstandings.

Some of the documents in the manual include:

- OSHA bloodborne pathogen standard
- Guidelines for Prevention of Transmission of HIV and Hepatitis B Virus to Health-Care and Public-Safety Workers
- Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Facilities, 1994
- Tuberculosis Fact Sheet
- Ryan White Law and Rules
- Exposure Report Form
- Public Health Service Guidelines for the Management of Health Care Worker Exposures to HIV and Recommendations for Post-Exposure Prophylaxis

- Recommendations for Follow-Up of Health Care Workers after Occupational Exposure to Hepatitis C Virus

The manual is not a substitute for an exposure control plan. It is a source of information and can clarify many requirements and answer many questions about infectious disease. The EMS Office will update the manual periodically to reflect developments in the field of infection control.

— Mike O'Keefe,
State Training Coordinator

VERMONT SAFE KIDS

Invites Applications for Community Safety Project Mini-Grants

Vermont SAFE KIDS is a non-profit organization dedicated to preventing childhood injuries in Vermont. Vermont SAFE KIDS operates through a volunteer board of directors from varied professions and organizations, and through local volunteers. Our work focuses primarily on the prevention of unintentional childhood injuries through education, media, co-sponsorship of safety fairs and other injury prevention events. Through local fundraising efforts, especially the annual Vermont SAFE KIDS Bike-a-Thon, and support of the National SAFE KIDS campaign, we are happy to announce the availability of Community Safety Project mini-grants. In prior years Vermont SAFE KIDS has funded a variety of projects, such as distribution of injury prevention devices, educational support materials for existing programs, and safety events. These are just a few examples, creativity is strongly encouraged! For further information or to obtain the simple one page application, please call Vermont SAFE KIDS at 847-6541 or 1-800-974-7055 or e-mail Kathy Keating *kathleen.keating@vtmednet.org.* Applications will be **due by February 15, 2001** and grant notifications will be made by March 1, 2001.

Toll-Free Number

Save yourself some money.

When calling EMS from within Vermont, use our toll free number:

1-800-244-0911

EMS Fax Number **1-802-863-7577**

Email **VTEMS@VDH.STATE.VT.US**

Training Update

CONTINUED FROM PAGE 9

applications were approved within two weeks of being complete. More than a third of the courses were approved on the same day the applications were complete.

Two EMT-B bridge courses took place. Because the students entering these courses had to be ECAs, these courses were slightly shorter than the standard EMT-B course.

Instructor Development

Seven more EMTs graduated from the EMS Instructor course in March 2000. They all received orientation to Vermont's rules and policies at the end of the course, together with two other EMTs who had finished the course years ago but had not coordinated courses or been oriented. In all, 71 EMTs from Vermont have completed the course since it was first conducted more than ten years ago. Most graduates are coordinating courses, but a significant number have never coordinated a course.

Certification Examinations

Every EMT who was due to take the test for recertification received a reminder and an exam registration form in the mail. With the cooperation of district officials, course instructors and EMTs, the number of times EMS office staff traveled to conduct EMT certification exams remained manageable. (See below.)

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000
Exam Trips	60	28	24	29	29	33	31	42	35

Esophageal Tracheal Combitube

The first three Combitube courses took place in EMS District 6 (the area around Central Vermont Hospital in Berlin) and EMS District 5 (the area around Northeast Vermont Regional Hospital in St. Johnsbury).

Written Examinations

The EMT-Intermediate exam underwent some minor revisions to reflect changes in terminology and to clean up a few typographical errors. EMS released a new EMT-B recertification written and practical exam. The written exam was based on the EMT-B refresher curriculum. The practical exam was shortened to three stations. A recertifying EMT who had difficulty at a station received assistance and coaching to a level of acceptable performance.

National Standard EMT-Intermediate Curriculum Revised

The National Highway Traffic Safety Administration (NHTSA) released a revision of the National Standard EMT-Intermediate Curriculum. Few states announced plans to adopt it as written. A number of states, including Vermont, decided to adapt it to meet their needs and resources.

EMS Education Agenda for the Future

NHTSA also released the EMS Education Agenda for the Future, a document designed to guide the progress of EMS education in this country. It calls for determination of core medical content by physicians, formulation of scope of practice by regulatory officials and conversion of the core content into national education standards by educators. The system envisioned in the document also calls for accreditation of EMS educational institutions and national EMS certification. The parts of the system are interdependent and, to be successful, must be implemented in a systematic manner. The goals of the Education Agenda are lofty and may not be fully achieved everywhere, but they call for each state to consider the document carefully and determine how it can best be implemented.

— Mike O'Keefe,
State EMS Training Coordinator

Number of people holding Vermont EMS certification as of 9/30/00:

ECA		972
EMT–Basic	(does not include advanced levels)	1211
EMT–I		629
EMT–P		74
Total EMTs at all levels:		**1,914**

File Update

Have you moved or changed your phone number or name since the last time you certified or recertified? Let us know se we can keep our records up-to-date.

Change of name and address form:

OLD INFORMATION:	NEW INFORMATION:
Name _____	Name _____
Address _____	Address _____
_____ Zip _____	_____ Zip _____
Phone _____	Phone _____
Certification number _____	

Send to: Vermont Dept. of Health, Division of Health Protection
EMS & Injury Prevention
P.O. Box 70, 108 Cherry Street
Burlington, VT 05402

Vermont Emergency Medical Services

108 Cherry Street
P.O. Box 70
Burlington, VT
05402

802-863-7310
1-800-244-0911
(within Vermont)